the direct health care cost center. Total resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates for food and utilities in the indirect health care cost center.

(C) Resident days used to calculate the upper payment limits and rates in the operating cost center and indirect health care cost center, less food and utilities, shall be subject to an 85 percent minimum occupancy requirement based on the following:

(i) Each provider that has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period shall have the resident days calculated at the minimum occupancy of 85 percent.

(ii) The 85 percent minimum occupancy requirement shall be applied to the resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider, unless the provider is allowed to file a projected cost report.

(iii) The minimum occupancy rate shall be determined by multiplying the total number of licensed beds by 85 percent. In order to participate in the Kansas medical assistance program, each nursing facility provider shall obtain proper certification for all licensed beds.

(iv) Each provider with an occupancy rate of 85 percent or

greater shall have actual resident days for the cost report period used in the rate computation.

(7) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(8) The effective date of the rate for existing providers shall be in accordance with K.A.R. 30-10-19.

(b) Comparable service, private pay rate limitations.

(1) For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the Kansas medical assistance program. Private pay rates reported to the agency on other than a per diem basis shall be converted to a per diem equivalent.

(2) The agency shall maintain a registry of private pay per diem rates submitted by providers.

(A) Providers shall notify the agency of changes in the private pay rate and the effective date of that change so that the registry can be updated.

(i) Private pay rate information submitted with the cost reports shall not constitute notification and shall not be acceptable.

(ii) Providers may send private pay rate notices by certified mail so that there is documentation of receipt by the agency.

(B) The private pay rate registry shall be updated based on the notification from the providers.

(C) The effective date of the private pay rate in the registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency.

(i) If the private pay rate effective date is other than the first day of the month, the effective date in the registry shall be the first day of the closest month. If the effective date is after the 15th, the effective date in the register shall be the first day of the following month.

(ii) For new facilities or new providers coming into the medicaid program, the private pay rate effective date shall be the issued certification date.

(3) The average private pay rate for comparable services shall be included in the registry. The average private pay rate may consist of the following variables:

(A) Room rate differentials. The weighted average private pay rate for room differentials shall be determined as follows:

(i) Multiply the number of private pay residents in private rooms, semiprivate rooms, wards, and all other room types by the rate charged for each type of room. Sum the resulting products of each type of room. Divide the sum of the products by the

total number of private pay residents in all rooms. The result, or quotient, is the weighted average private pay rate for room differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average private pay rate when there are room rate differentials.

(iii) Failure to submit the documentation shall limit the private pay rate in the registry to the semiprivate room rate.

(B) Level-of-care rate differentials. The weighted average private pay rate for level-of-care differentials shall be determined as follows:

(i) Multiply the number of private pay residents in each level of care by the rate they are charged to determine the product for each level of care. Sum the products for all of the levels of care. Divide the sum of the products by the total number of private pay residents in all levels of care. The result, or quotient, is the weighted average private pay rate for the level-of-care differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average rate when there are level-of-care rate differentials.

(iii) Failure to submit the documentation may delay the effective date of the average private pay rate in the registry until the complete documentation is received.

(C) Extra charges to private pay residents for items and services specified in K.A.R. 30-10-15a may be included in the weighted average private pay rate if the same items and services are allowable in the Kansas medical assistance program rate.

(i) Each provider shall submit documentation to show the calculation of the weighted average extra charges.

(ii) Failure to submit the documentation may delay the effective date of the weighted average private pay rate in the registry until the complete documentation is received.

(4) The weighted average private pay rate shall be based on what the provider receives from the resident. If the private pay charges are consistently higher than what the provider receives from the residents for services, then the average private pay rate for comparable services shall be based on what is actually received from the residents. The weighted average private pay rate shall be reduced by the amount of any discount received by the residents.

(5) The private pay rate for medicare skilled beds shall not be included in the computation of the average private pay rate for nursing facility services.

(6) When providers are notified of the effective date of the Kansas medical assistance program rate, the following procedures shall be followed:

(A) If the private pay rate indicated on the agency

register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows:

(i) If the average medicaid case mix index is greater than the average private pay case mix index, the Kansas medical assistance program rate shall be the lower of the private pay rate adjusted to reflect the medicaid case mix or the calculated Kansas medical assistance rate.

(ii) If the average medicaid case mix index is less than or equal to the average private pay case mix index, the Kansas medical assistance program rate shall be the average private pay rate.

(B) Providers who are held to a lower private pay rate and subsequently notify the agency in writing of a different private pay rate shall have the Kansas medical assistance program rate adjusted on the later of the first day of the month following the date upon which complete private pay rate documentation is received or the effective date of a new private pay rate.

(c) Rate for new construction or a new facility to the program.

(1) The per diem rate for newly constructed nursing facilities or a new facility to the Kansas medical assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

(2) No rate shall be paid until a nursing facility financial and statistical report is received and processed to determine a rate.

(d) Change of provider.

(1) The payment rate for the first 24 months of operation shall be based on the base-year historical cost data of the previous owner or provider. If base- year data is not available, the most recent calendar year data for the previous provider shall be used. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to the new provider's rate.

(2) Beginning with the first day of the 25th month of operation, the payment rate shall be based on the historical cost data for the most recent calendar year submitted by the new provider.

(e) Determination of the rate for nursing facility providers reentering the medicaid program.

(1) The per diem rate for each provider reentering the medicaid program shall be determined from either of the following:

(A) A projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or

more; or

(B) the last historic cost report filed with the agency, if the provider has actively participated in the program during the most recent 24 months.

(2) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), a settlement shall be made in accordance with subsection (f).

(f) Per diem rate errors.

(1) If the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider with an identified overpayment is no longer enrolled in the medicaid program, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation, unless other arrangements have been made to reimburse the agency. A net settlement may occur if a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit of the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost

report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(g) Out-of-state providers.

(1) The rate for out-of-state providers certified to participate in the Kansas medical assistance program shall be the rate approved by the agency.

(2) Out-of-state providers shall obtain prior authorization by the agency.

(h) Reserve days as specified in K.A.R. 30-10-21 shall be

paid at 67 percent of the Kansas medical assistance program per diem rate.

(i) Determination of rate for ventilator-dependent resident.

(1) The request for additional reimbursement for a ventilator-dependent resident shall be submitted to the agency in writing for prior approval. Each request shall include a current care plan for the resident, the most current resident assessment, and an itemized expense list for implementing that care plan. The additional reimbursement shall not include the cost of durable medical equipment.

(2) All of the following conditions shall be met in order for a resident to be considered ventilator-dependent.

(A) The resident is not able to breathe without mechanical ventilation.

(B) The resident uses a ventilator for life support 24 hours a day, seven days a week.

(C) The resident has a tracheostomy or endotracheal tube.

(3) The provider shall be reimbursed at the Kansas medical assistance program daily rate determined for the nursing facility plus an additional amount approved by the agency for the ventilator-dependent resident. The provider shall submit a budget with the detail of the expenditures requested to care for the ventilator-dependent resident. The additional reimbursement